received immunotherapy. The reasons for not receiving immunotherapy included transplant related death (6%), inadequate recovery for acute toxicity (16%), failure to obtain insurance coverage (8%), progression of disease (8%), and patient's/physician's choice (10%). The median time to start therapy was 70 days (range 32–100 days). There were no immunotherapy related deaths. By NCI Common Toxicity Criteria, the following grade 3–4 toxicities were seen: grade 4 hematological (n = 4), grade 3 infection (n = 3), grade 4 circulatory (n = 1), grade 4 gastrointestinal (n = 1), grade 3 neurological/neuro-central (n = 1), and grade 3 dermatology (n = 1). The most common toxicity was erthyema/induration at injection sites. For all patients, the median follow-up is 50 months. If one compares the outcome of patients who survived transplant and did not have early relapse as to whether they received immunotherapy or not, the following outcomes were seen. The survival rate is 63% versus 43% for patients with inflammatory disease. For stage IV disease the median survival without immunotherpy was 20 months versus 39 months with immunotherapy. Median time to disease progression was 18 months with immunotherpy and 12 months without immunotherapy. Immunotherapy with IL-2 and GM-CSF is well tolerated after ASCT. Immunotherapy appears to impact on survival but relapse still remains a problem for patients with advanced breast cancer after ASCT.

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USE OF PEG-FILGRASTIM OR FILGRASTIM AFTER HIGH DOSE CONDITIONING WITH BEAC CHEMOTHERAPY IN PATIENTS WITH LYMPHOMA

Richart, J.M.[1], Kallogjeri, D.[1], Oliver, D.A.[1], Petruska, P.J.[1], Pincus, S.M.[1] Saint Louis University, Saint Louis, MO.

Colony stimulating factors are routinely used after high dose chemotherapy and autologous transplant. Few data are available addressing the efficacy of PEG-filgrastim. Thirty-one consecutive patients who underwent BEAC conditioning and autologous transplant for lymphoma at a single institution were analyzed. One patient died prior to neutrophil recovery and is not included in this analysis. Nineteen patients received filgrastim either 480 mcg if they weighed >60 kg or 300 mcg for a weight <60 kg subcutaneously daily starting day +5 and continuing until ANC > 500. Eleven patients received 6 mg PEG-filgrastim on day +1. The median number of CD34+ cells/kg was 3.9 (1.7–8.2) in the filgrastim group and 2.9 (1.7–9.1) in the PEG-filgrastim group. The median number of prior cytotoxic chemotherapeutic regimens was 1 (1–3) in the filgrastim group and 1 (1–2) in the PEG-filgrastim group. Diagnoses in the filgrastim group: diffuse large B-cell lymphoma (6), follicular lymphoma (7), or mantle cell lymphoma (6). Diagnoses in the PEG-filgrastim group: diffuse large B-cell lymphoma (2), follicular lymphoma (3), mantle cell lymphoma (3), anaplastic T cell lymphoma (1), or cutaneous T cell lymphoma (2). For the filgrastim group, the median time to neutrophil engraftment was 10 days (9–13); the median time to platelet engraftment was 10 days (8–15). For the PEG-filgrastim group the median time to neutrophil engraftment in was 11 days (8–16); the median time to platelet engraftment was 14 days (10–16). The median number of injections in the filgrastim group was 5 (4–7). **Conclusions:** Both filgrastim and PEG-filgrastim allow for prompt neutrophil recovery in patients undergoing BEAC conditioning and autologous transplant. Factors other than efficacy such as convenience, patient comfort and cost should be considered when choosing a post transplant colony stimulating factor.

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DOES GM-CSF ALTER THE PROGNOSTIC SIGNIFICANCE OF EARLY LYMPHOCYTE RECOVERY POST-AUTOGRAFTING FOR NHL?

Tiwari, D.[1], Vij, R.[1], Devine, S.[1], DiPersio, J.[1], Khoury, H.J.[2] 1. Washington University School of Medicine, St. Louis, MO; 2. Emory University School of Medicine, Atlanta, GA.

Early lymphocyte recovery, assessed by an absolute lymphocyte count (ALC, > 500/mcl) measured on post-transplant day 15, is an independent prognostic factor for disease-free and overall survival after autografting multiple myeloma, NHL, metastatic breast cancer, and AML. The effect of post-transplant administration of myeloid growth factors on the prognostic significance of ALC is unknown. We analyzed the outcomes of 268 relapsed chemosensitive NHL patients autografted at Washington University between January 1996 and May 2003, divided into 2 groups based on their day +15 ALC counts (>500, n = 151; <500, n = 117). All patients received GM-CSF 250 mcg/kg subcutaneously starting on day 0 to hasten neutrophils recovery. Patient were well balanced between the 2 groups with regards to age, gender, preparative regimen, prior therapy, time from diagnosis to transplant, and number of CD34+ cells infused within each grade. Median follow-up was 22 months. No associations between early lymphocyte recovery and reduction of post-transplant complications, or improvement of disease-free and overall survival were observed. Late lymphocyte recovery (ALC < 500 on day +15) was independently associated with a delay in platelet recovery (29 vs 21 days, $P = .0005$) in patients who have not received pre-transplant rituximab. We conclude that, in this single-center retrospective analysis, the favorable prognostic significance of post-transplant early lymphocyte recovery could not be reproduced and may have been due to post-transplant administration of GM-CSF.

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EBV-ASSOCIATED POST-TRANSPLANTATION LYMPHOPROLIFERATIVE DISORDERS; A REPORT OF THREE CASES IN AUTOLOGOUS HSCT PATIENTS OF T CELL LYMPHOMA

Koseki, M.[1], Uryu, H.[1], Takeuchi, M.[1], Matsue, K.[1] Kameda Medical Center, Kamogawa, Chiba, Japan.

Epstein-Barr virus(EBV)-associated post-transplant lymphoproliferative disorders(PTLD) mostly occur in solid organ and allogeneic hematopoietic stem cell trnasplant(HSCT) patients with immunosuppression associated with high mortality rate but following autologous HSCT is rare complication. We report 3 cases of PTLD after autologous HSCT for T cell lymphoma. One is successfully treated with rituximab in durable remission but the other 2 without rituximab therapy died in aggressive clinical courses. T cell lymphoma could be a risk factor of developing PTLD after autologous HSCT due to its specific T cell dysfunction. Currently, use of rituximab provides far better outcome that biopsy confirmed diagnosis should be made in those high risk patients.

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HEMATOPOIETIC STEM CELL TRANSPLANTATION (SCT) A SINGLE CENTER 10 YEARS EXPERIENCE

Guillermo, C.[1], Diaz, L.[2], Isaurralde, H.[1], Topolansky, L.[2], Baubeta, A.[1], Lizarralde, A.[1], Testa, G.[1], Perdomo, S.[1], Perdomo, A.[1], Lavagna, G.[1], Nese, M.[2] 1. Centro IMPASA de Trasplante de Medula Osea CITMO, Montevideo, Uruguay; 2. Hematological Department. Medicine Department, University of Medicine, Montevideo, Uruguay.

We evaluated the results of SCT at CITMO between 1995 and 2005. We performed 323 SCT; 281 autologous (auto-SCT): 164 lymphomas (Lym), 49 MM, 43 AL, 23 solid tumors (ST), 2 others; 42 allogeneic (allo-SCT): 11 AL, 11 CML, 8 MDS, 6 AA, 3 Lym, 3 others. Nineteen auto-SCT and 10 allo-SCT were tandem. Median age was 44 years (3–65), 160 male and 121 female for auto-SCT, 39 years (6–58), 26 male and 16 female for allo SCT. The conditioning regimens were: CVB, BEAC, BEAM in Lym; BuCy in AL; Melfalan in MM; Maxi-ICE in ST; Cy-ATG in AA. We used a maintenance treatment in ALL with Mtx and 6 MP. Stem cells mobilized with G-CSF were obtained from BM in 16, BM + PB in 127, and PB in 183. The median MNC and CD34 infused was 9×10^8/kg and 9×10^6/kg in auto-SCT and 7×10^8/kg and 8×10^6/kg in allo-SCT. Hematological recovery median time was: 10 and 11 days for neutrophils; 14 and 18 for platelets in auto and allo respectively. One hundred days mortality was 2.6% in auto-SCT, 5.3% in tandem-SCT, and 31% in allo-SCT; hospitalization median time was 20, 26, and 46 days, respectively. Ten year overall survival in auto-SCT was: NHL 38%; HL 75%; AML 45%; ALL 73%; MM 36%; germinal tumor 63%, and 15% in breast cancer, in auto-SCT tandem was: MM 57%, NHL 60%, and HL 67%, in allo-SCT was: AA 33%, CML 41%; AL